STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 121104-001**

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 27th day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 3, 2011, XXXXX, authorized representative of her adult son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On May 10, 2011, after a preliminary review of the material submitted the Commissioner accepted the request for external review.

The Petitioner receives health care benefits under benefit plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on May 18, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner is a resident of XXXXX, Texas. On December 18, 2009, he sustained a puncture wound to his left groin causing massive blood loss. He was taken to the closest

hospital, XXXXX Hospital (XXXXX) in XXXXX. After blood vessels were repaired he was placed in the intensive care unit. Petitioner was discharged on December 24, 2009.

The hospital's charges totaled $60,265.01. The hospital does not participate with BCBSM or the local Blue Cross Blue Shield plan. BCBSM paid its approved amount of $19,027.20, leaving the Petitioner's parents responsible for the balance of $41,237.81.

The Petitioner's mother appealed BCBSM's payment amount through its internal grievance process. BCBSM held a managerial-level conference on February 24, 2011, and issued a final adverse determination dated February 28, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the care Petitioner received at XXXXX from December 18 through December 24, 2009?

IV. ANALYSIS

Petitioner's Argument

Petitioner's mother states XXXXX believes BCBSM is underpaying claims for the dates of service in question and is not being truthful in this matter. Petitioner's mother believes BCBSM is required to pay significantly more for the services provided by XXXXX.

The Petitioner's parents do not believe that XXXXX should "balance bill" them for the $41,237.81 that BCBSM will not pay. The Petitioner also believes BCBSM should provide an itemized list detailing the services and fees that were covered to equate to the approved amount of $19,027.20.

BCBSM's Argument

BCBSM states that its payment is based on its "approved amount" for covered services as provided on page 3.1 of the certificate. The certificate does not guarantee that charges will be paid in full even if the care is provided for an emergency condition.

To determine its payment level for each service, BCBSM states it applies a resource based relative value screen scale (RBRVS) which is a nationally recognized reimbursement structure developed by physicians. The RBRVS reflects the resources required to perform each service, including physician time, specialty training, malpractice premiums, and practice overhead. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training and medical practice.

BCBSM states its approved amount is the same for both participating and nonparticipating providers. Participating providers have entered into a contractual agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM members. However, nonparticipating providers have no contractual obligation to accept the approved amount as payment in full and may bill a BCBSM member for any balance over BCBSM's approved amount.

BCBSM understands that the Petitioner's mother feels they had no choice in which provider to use due his unforeseen medical emergency. However, BCBSM maintains that there is nothing in the certificate that requires it to pay more than its approved amount for these services even if the care was provided on an emergency basis or even if no participating providers were available.

BCBSM states that the local BCBS plan in Texas was contacted and the maximum payment amount was approved based on the services reported as an all-inclusive rate calculated on a per day basis. BCBSM also stated there was no itemized listing provided by the local BCBS plan in Texas and therefore such information is not available.

Commissioner's Review

Under the certificate, enrollees incur the least out-of-pocket cost if they receive services from providers who participate with BCBSM. The certificate (page 3.55) explains the consequences when enrollees use nonparticipating providers:

> If the provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial because BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency.
>
> * * *
>
> – You will also be responsible for the difference between our approved amount and the amount charged by the nonparticipating provider.

The certificate describes how benefits are paid when services are received from a nonparticipating provider such as XXXXX. BCBSM pays only its approved amount for covered services. The certificate does not guarantee that the nonparticipating provider's charge will be paid in full. "Approved amount" is defined in the certificate (page 7.2) as "the lower of the billed charge or our maximum payment level for the covered service."

As a nonparticipating provider, XXXXX is not bound to accept BCBSM's approved amount as payment in full for its services and it may bill the Petitioner for any difference between its charge and BCBSM's approved amount.

The Commissioner finds that BCBSM correctly processed the hospital's services under the terms and conditions of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of February 28, 2011, is upheld. BCBSM is not required to pay any additional amount for the care Petitioner received at XXXXX Hospital.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.